

**ATTESTATION:** Please identify the nursing courses which include **all** topics/requirements specified below **and** a clinical rotation in geriatrics, thereby meeting both state of Kansas and federal training requirements for **nurse aide** certification, sign the attestation below, and return this form to Health Occupations Credentialing.

*Requirements/Required Topics:*

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| <p>1.     <u>Basic Skills</u><br/> Communication and interpersonal skills<br/> Infection control<br/> Safety/emergency procedures, including the Heimlich maneuver<br/> Promoting resident independence<br/> Respecting resident rights</p>   | <p>4.     <u>Basic Restorative Services</u><br/> Safe use of mechanical devices<br/> Normal range of motion and positioning<br/> Care and use of prosthetic and orthotic devices</p>   |
| <p>2.     <u>Basic Nursing Skills</u><br/> Taking and recording vital signs<br/> Measuring and recording height and weight<br/> Caring for the resident environment<br/> Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor<br/> Caring for residents when death is imminent</p> | <p>5.     <u>Mental health and social service needs</u><br/> Modifying aide's behavior in response to residents' behavior<br/> Awareness of developmental tasks associated with the aging process<br/> How to respond to resident behavior, using the resident's family as a source of emotional support</p> |
| <p>3.     <u>Personal Care Skills</u><br/> Cleanliness and grooming<br/> Nutrition and fluids<br/> Lifting and moving the resident<br/> Toileting<br/> Skin care</p>  | <p>6.     <u>Care of Cognitively Impaired Residents</u><br/> Communicating with cognitively impaired residents</p>   |

The following nursing course(s) meet all the requirements listed above:

Name of Course	Number	Name of Course	Number
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Name of Course	Number	Name of Course	Number
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I do hereby attest that the information supplied on this form is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided on this form.

Nursing Department Coordinator Name (Please print.)	Signature
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Telephone Number	E-mail
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School
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